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**THE WALL STREET JOURNAL.****Health & Medicine (A Special Report): The Payers --- Gotcha! Health insurers go all out in their Effort to ferret out bogus claims***Wall Street Journal*; New York; Oct 23, 1997; [By Robert Langreth](#);

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**Abstract:**

*A few years ago, New York state's largest health insurer wouldn't consider sending undercover agents to investigate doctors because it was understaffed and fraud wasn't a priority. But today, Empire is cracking down on health-care providers in a bid to recover at least some of the tens of millions of dollars of fraudulent claims that are submitted to the New York-based nonprofit company each year.*

*The mastermind behind Empire's aggressive antifraud effort is a former New Jersey state trooper, Louis Parisi. A burly 53-year-old Brooklyn native, Mr. Parisi aims to help keep premium costs down by keeping bad doctors from abusing the system. He doesn't confine his prey to doctors -- home-care providers, pathology labs and patients who cheat the system are also in his cross hairs.*

*Still, with Mr. Parisi's budget at roughly \$3 million, Empire claimed a whopping 12-to-1 return on its investment last year. And Mr. Parisi says this year's savings easily will exceed \$40 million because of the efforts of his hard-working staff. Though few of his targets end up in jail, the financial penalty often exceeds restitution: Dishonest doctors face getting booted from Empire's managed-care networks, while any claims filed by those doctors for traditional fee-for-service care are red-flagged for extra scrutiny. Flagrant violators also risk losing their licenses.*

**Full Text:**

Copyright Dow Jones & Company Inc Oct 23, 1997

Several times each week, workers from [Empire Blue Cross & Blue Shield](#) head out to doctors' offices equipped with miniature tape recorders hidden in sunglass cases or pens. Posing as patients, they visit diet doctors, dermatologists, chiropractors and other health-care providers.

The goal: to catch greedy doctors who submit fraudulent health-insurance claims.

A few years ago, New York state's largest health insurer wouldn't consider sending undercover agents to investigate doctors because it was understaffed and fraud wasn't a priority. But today, [Empire](#) is cracking down on health-care providers in a bid to recover at least some of the tens of millions of dollars of fraudulent claims that are submitted to the New York-based nonprofit company each year.

The mastermind behind [Empire](#)'s aggressive antifraud effort is a former New Jersey state trooper, Louis Parisi. A burly 53-year-old Brooklyn native, Mr. Parisi aims to help keep premium costs down by keeping bad doctors from abusing the system. He doesn't confine his prey to doctors — home-care providers, pathology labs and patients who cheat the system are also in his cross hairs.

Michael Stocker, [Empire](#)'s chief executive officer, says: "He's taken a company that was beleaguered and didn't have the will [to fight fraud] and showed them how to do it."

In the past, "fraud was considered a cost of doing business" by insurers, Mr. Parisi says. Losses from fraud simply were passed on to policyholders, and if "it didn't affect the bottom line, there wasn't much interest in doing much about it."

That has changed in recent years, as companies — and politicians — have begun clamoring to keep rates down. Suddenly, passing on extra costs isn't so easy. New laws in 16 states, including Florida, New Jersey and New York, now require insurers to beef up their antifraud efforts. The result: While just seven years ago most health insurers didn't have antifraud departments, today, 90% of them do.

Mr. Parisi's philosophy is simple: use all means possible to ferret out and investigate possible bogus or exaggerated claims — no matter how small. Once fraud or overbilling is established, make the perpetrators pay the money back — plus interest and the cost of the investigation.

"The only way to deal with white-collar crime is to make it too costly to do it," says Mr. Parisi. With the criminal-justice system already overloaded with violent criminals, "you're not going to accomplish much with hollow threats of jail time."

His approach has reaped dividends. [Blue Cross](#) estimates it saved \$36.1 million in 1996 through 12,400 fraud investigations, up 43% from \$25.2 million in 1994. The more-recent figure is a little over 1% of the \$3.16 billion of claims the insurer processed last year, suggesting that the fraud fighters have hardly exhausted their supply of targets. Government and industry estimates put the incidence of fraud at 3% to 10% of claims nationwide — making [Empire](#)'s share between \$94 million and \$316 million.

Still, with Mr. Parisi's budget at roughly \$3 million, [Empire](#) claimed a whopping 12-to-1 return on its investment last year. And Mr. Parisi says this year's savings easily will exceed \$40 million because of the efforts of his hard-working staff. Though few of his targets end up in jail, the financial penalty often exceeds restitution: Dishonest doctors face getting booted from [Empire](#)'s managed-care networks, while any claims filed by those doctors for traditional fee-for-service care are red-flagged for extra scrutiny. Flagrant violators also risk losing their licenses.

Mr. Parisi's unit has uncovered many dubious operations, including a doctor who billed for \$250,000 of ultrasound exams of the scrotum performed on women; a home-health-care agency that charged for services delivered to dead AIDS patients; a podiatrist who billed for removing all the toenails from several of his patients several times; and an internist who practiced under her maiden name, but used her married name to submit \$9,000 of claims for treating herself, including self-mammography and rectal exams.

Critics contend that investigators like Mr. Parisi, in their zeal to catch fraud, sometimes push too far. Under the current system, "doctors are guilty until proven innocent," contends Debra Weissman, a White Plains, N.Y., consultant who advises doctors and hospitals on billing practices.

"The rules change all the time," she says, and are so full of gray areas that insurance companies' own advice lines for doctors often can't provide the right answers. Physicians may be left to guess at the correct billing code for a procedure, Ms. Weissman explains, and "then the next thing they know, they are being sued and have to refund all this money."

"That's nonsense," Mr. Parisi responds. The rules "have been around for decades. You don't bill for services you don't provide. You don't upcode [exaggerate the severity of a condition]. The only gray area is medical necessity, and that's dealt with by medical professionals" on [Empire](#)'s staff.

He says he doesn't think all doctors are crooks. But "there are more than 70,000 doctors in New York state, and even 3% of 70,000 is enough to wreak havoc."

Mr. Parisi took up fraud fighting in 1987, well before it became a hot issue, leaving his state trooper job to head up New Jersey's insurance-fraud unit. There he was successful but also controversial. Some doctors under investigation by his department sued the state, accusing it of using threats of criminal prosecution to extort hefty fines for unproven offenses.

The state, without admitting wrongdoing, eventually settled out of court and agreed to pay a portion of the doctors' legal fees. Mr. Parisi scoffs at the allegations, saying he has been sued a number of times and personally never paid a penny.

②Empire executives hired Mr. Parisi in 1995 to bolster its antifraud efforts after U.S. Senate investigators and state regulators had blasted the company for its inattention to the problem. He quickly hired six new investigators, added a toll-free antifraud hot line so patients could snitch on their doctors, started assigning undercover work and bought a high-tech **software** system that searches claims data for patterns indicative of potential fraud.

Leads come from many sources. One of Mr. Parisi's favorite techniques is to look into doctors whose advertisements hint at insurance reimbursement for cosmetic services, such as weight-loss treatments or chemical skin peels, which aren't covered. Often, investigation reveals these physicians are doctoring claims.

Mr. Parisi's team also keeps a watchful eye on claims from doctors or others who attend seminars on "revenue-enhancing" billing techniques. Some of these seminars, Mr. Parisi contends, teach upcoding and "unbundling," billing a single operation as many small procedures to increase reimbursement.

Many subtle frauds, however, may only reveal themselves in unusual billing patterns over months or years. Here's where ②Empire's **software** system, from ②International Business Machines Corp., comes into play. It scans as much as six years of **claims** data searching for hundreds of potential indicators of **fraud**, such as how often **d ctors** perform various medical procedures, or whether they are charging much more per patient visit than their peers, or whether their huge number of office visits are suspiciously concentrated in a few patients.

The **computer** rates health-care providers according to how much they deviate from their peers in those categories; doctors who are way off the scale in one or more categories with no obvious explanation may be committing **fraud**. For example, **doctors** who file far more "back **claims**," those for office visits from months earlier, than any of their peers could be fabricating visits that never occurred.

In early 1996, ②Empire's **computer** operators discovered that a Manhattan internist had billed for an improbable 2,377 "comprehensive" office visits in a yearlong period -- or 46 a week -- far more than any other doctor in the company's network. Comprehensive exams are supposed to last at least 40 minutes and are generally reserved for cases where a doctor has discovered signs of a devastating illness such as cancer and must decide what to do next. "It's physically impossible" for a doctor to perform that many comprehensive visits a year, says Karen Rehne, who supervises ②Empire's **computer-fraud** unit.

A review of the doctor's records confirmed that, in fact, many of the visits were for colds, backaches and other everyday maladies, and that the doctor's staff routinely performed unnecessary diagnostic tests, such as electrocardiograms on teenagers with no signs of heart problems. The doctor recently agreed to pay back \$1 million, ②Empire says.

**C mputer** analysis also found that a certain dentist was responsible for half of all claims to ②Empire for a rare type of sinus surgery. Patients would come in to have their teeth pulled, a \$200 procedure in the dentist's office, but he would also bill \$1,600 or more for the sinus surgery. Amazingly, the dentist claimed to have performed this surgery -- a particularly bloody operation that usually requires hospitalization -- in his office, mostly on HIV-positive patients, which he specialized in treating.

②Empire says it believes the surgeries were never performed. After the company confronted the dentist, he agreed to refund \$141,000.

Nabbing dishonest health-care pro-viders usually involves interviewing current and former patients to see whether the doctor really performed the services claimed, and scrutinizing the doctor's medical records. But sometimes a

little detective work is required. One internist came under suspicion because he submitted more claims for larynx exams than all but two throat specialists in Empire's system.

When Empire queried the doctor, he submitted meticulous records documenting every disputed procedure. On closer examination of the record sheets, however, an investigator found a small but revealing watermark that exposed the doctor's scheme. "The records were for 1992, but the paper wasn't manufactured until 1995 or 1996," says Norman Geller, medical director for Empire's fraud unit. The doctor paid back \$200,000.

For other cases, investigators must go undercover. Typically, these occur when a doctor is falsifying diagnoses to get reimbursed for cosmetic procedures. Patients who want to keep getting the free treatments may be in cahoots with the doctor and unwilling to help out investigators, so "the only way to find out what the doctor is doing is to go in there yourselves," Mr. Parisi says. The typical ploy: Healthy investigators visit medical offices for cosmetic services, and then wait to see whether the doctors submit false claims.

In recent months, undercover investigators have caught diet clinics that provided weight-loss advice and then billed for treating asthma or hypertension; a gym that gave clients back massages and then sent in \$200,000 of claims for fictitious chiropractic care and neuromuscular exams; and several dermatologists who gave patients facials or hair-replacement treatments and then claimed they had performed acne surgery or other covered procedures.

So how does investigating doctors compare with being a state trooper? Though it's time-consuming, Mr. Parisi says, medical fraud is easier and a lot safer than dealing with violent felons. "There's a paper trail, and you don't get shot at or beat up."

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Mr. Langreth is a staff reporter in The Wall Street Journal's New York bureau.

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## Reengineering Health Care

Washington Technology; Vienna; Jul 13, 1995; [Gene Koprowski Contributing Writer](#);

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**Abstract:**

*As an aide to Sen. Ted Kennedy in the early 1970s, Phil Caper frequently fretted over soaring health-care costs. It was, at that time, part of his job. Eventually, those concerns led Caper, a physician schooled at UCLA, to help co-author several bills, including the sweeping legislation that fostered health maintenance organizations, or HMOs. A few years later, in 1977, Caper was appointed to a federal health-care costs advisory commission. "It was divine retribution," quipped Caper. "A Senate aide was forced to implement a program he'd written. It was kind of one version of hell."*

*That's what led him to create Codman Research, Lebanon, N.H., and to market database management technology that could help locate information about local trends, and thus reduce health-care costs overall. What does Kennedy, Caper's old friend and mentor, think of the information technology solution to the health-care concerns of the country? Caper circulated a paper that sought to bring such issues to the attention of the man for Massachusetts, and others in power in the capital. "{But} you know how it is in Washington," said Caper. "It is very hard to turn around once you've made public commitment. You can't admit a mistake. It looks as though you're waffling."*

*The technology solution to these problems would seem complex; but it is actually quite simple. For example, take a trend discovered by Blue Cross and Blue Shield of Omaha, Neb., using the Codman technology. The folks in Omaha seek the comforts of a psychiatrist's couch more frequently than the residents of Lincoln. Are they distinctly more distraught in northeast Nebraska than in the state capital? Or do the doctors in Omaha simply prescribe too much psychiatric treatment for their patients?*

**Full Text:**

Copyright Technews Inc. Jul 13, 1995

Local solutions, BPR and information technology shed new light on containing health care costs

As an aide to Sen. Ted Kennedy in the early 1970s, Phil Caper frequently fretted over soaring health-care costs. It was, at that time, part of his job. Eventually, those concerns led Caper, a physician schooled at UCLA, to help co-author several bills, including the sweeping legislation that fostered health maintenance organizations, or HMOs. A few years later, in 1977, Caper was appointed to a federal health-care costs advisory commission. "It was divine retribution," quipped Caper. "A Senate aide was forced to implement a program he'd written. It was kind of one version of hell."

Caper and his cohorts found that in the real world a federal solution to health-care cost reform -- such as the Medicare program currently being debated by Congress -- was unworkable. Health care was administered locally; thus, local solutions were needed. Moreover, more data was required to discern treatment trends on the local level, if costs were to be contained.

That's what led him to create Codman Research, Lebanon, N.H., and to market database management technology that could help locate information about local trends, and thus reduce health-care costs overall. What does Kennedy, Caper's old friend and mentor, think of the information technology solution to the health-care concerns of the country? Caper circulated a paper that sought to bring such issues to the attention of the man for Massachusetts, and others in power in the capital. "{But} you know how it is in Washington," said Caper. "It is very hard to turn around once you've made public commitment. You can't admit a mistake. It looks as though you're waffling."

#### A Nebraska case study

The technology solution to these problems would seem complex; but it is actually quite simple. For example, take a trend discovered by Blue Cross and Blue Shield of Omaha, Neb., using the Codman technology. The folks in Omaha seek the comforts of a psychiatrist's couch more frequently than the residents of Lincoln. Are they distinctly more distraught in northeast Nebraska than in the state capital? Or do the doctors in Omaha simply prescribe too much psychiatric treatment for their patients?

A little over two years ago, Blue Cross and Blue Shield couldn't even begin to contemplate those questions. The company -- just like hundreds of other health insurers across the nation -- didn't have the requisite data. They were quite primitive in their use of information from health-care claims. Data was stored in mainframe **computers**, which were jealously guarded by management information systems departments. And the whole system was geared toward paying claims -- writing checks -- rather than managing costs of care. Health-care concerns were not run as sound businesses.

"Good management has been an unheard of commodity in this system," said Caper, Codman's CEO and a physician who today consults with health insurers. "Doctors were always rewarded for whatever they did."

But today, as costs escalate, attitudes in the insurance industry are changing. The move toward managed care is altering the dynamics of medical practice, and shifting the burden of financial risk from the insurance company to the physician. The whole idea is that physicians will now prescribe necessary treatments, rather than those that just might be helpful. And information technology is helping negate payments to doctors that previously would have gone unchallenged, as was often the case with Medicare.

Blue Cross and Blue Shield of Nebraska, which provides health-care coverage for about 400,000 people, more than any other insurer in its state, has used client/server technology, relational databases and expert systems **ftware** to slash close to \$5 million in health care costs in the last two years alone. By bringing information from the mainframe to the desktop PC, insurers are putting managerial controls into the process. Moreover, they are quietly succeeding with a technology-driven, market-based solution to the cost concerns Ira Magaziner and Hillary Clinton resurrected during 1993 and 1994.

"We are forcing some accountability back to the system. Providers can't keep inventing treatments for which there is no net effect for the population -- treatments that have promise but no results," said Steve Martin, vice president of BCBSN. "The credo of the physician is 'First, do no harm.' But historically, we've been ignoring prescribed treatment that does financial harm."

The insurance claim is the prime source of data used to examine physicians' performance and practices. With the health-care informatics technology, Blue Cross and Blue Shield of Nebraska is taking that information and examining it in ways never before possible. "In the past, we had claims data, physician data and enrollment data, but they were on separate platforms," said Terry Groves, senior vice president of technology at BCBSN. "We had to go through the entire file to find anything. It was laborious."

Many functions of the Amdahl 5995/700A mainframe have been moved to a more efficient client/server system, which is already providing cost-saving results. A Digital Equipment Corp. Alpha processor houses the Pandora medical database **software** from Codman. It is linked to five token-rings, three Compaq servers outfitted with **Novells ftware** and connected to some 255 IBM PCs, and an Oracle relational database in BCBSN's Omaha

office campus, said Groves.


Claims analysts such as Sally Hrdy tap into that data and create reports, which analyze treatment trends in the insurance company's service area. She can accomplish in hours now what used to take months. But, even more important than the technology itself is what the new information can do. Scrolling through the claims database on her 486-based PC, Hrdy recently studied the differences in the practice styles of psychiatrists in Lincoln and Omaha. Some 42 doctors with 6,558 patients were scrutinized. The Blue Cross analyst found that psychiatrists in Omaha produced more medical claims per patient than did their colleagues in Lincoln. Were the patients in northeastern Nebraska in an exceptionally poorer state of mental health than those in the state capital? No, it was simply that the doctors there were prescribing too much treatment — out of habit.

"The trend of generating large numbers of claims per patient by Omaha psychiatrists is apparently driving the high number of claims per capita for the entire Omaha area," said Hrdy. "It is reasonable to say that as the number of available patients in the area increases, the number of claims per patient for psychiatric claims decreases. It also appears that as patient load increases, the claims per patient decrease."

#### Analytical software makes sense of data

**Software** from Codman Research Group, called Pandora, serves as an analytic engine for the insurer and was used in creating that report. All types of raw data are imported into the system — data from doctors' offices, hospitals, pharmacies. Codman converts it into a population-based database with local data adjusted for age, sex and date of service, the number of office visits per thousand and the number of lab tests per office visit.

The claims analyst, such as Hrdy, submits a query from her PC and receives the profile she asked for, whether it is a population-at-risk profile, a provider profile, the number of lab tests per visit, the typical charge per visit, or charges per capita. Patient cohorts can also be retrieved — such as the number of diabetics or asthmatics in the service population. The data can be used to compare rates and costs of service at different sites in a state, and also determine the final outcome of the care given. That is, whether the treatment was successful.

Blue Cross and Blue Shield of Nebraska is also using CodeReview **software**, devised by HPR in Boston. When a doctor submits a claim to the insurer, he uses one of 10,000  American Medical Association approved codes for each treatment. The CodeReview **software** reads each claim, and looks for all possible combinations of codes that don't seem proper. Such strange numbers may mean that a physician is billing for more complicated procedures than he actually prescribed, or that he has billed for more than one procedure at a time. When this **software**, and a related product called Patterns of Treatment, discern an irregularity in the billing, part of the claim may be denied.

During the last 12 months, Martin said, seven studies of treatment patterns have been performed by Blue Cross analysts in Omaha using this type of technology. Claim data from 1992 and 1993 was used, and was screened using algorithms developed in statistical-oriented programming language for bad records and lost codes. The studies examined podiatry, dermatology, surgeons and other providers. The technology enabled the insurer to challenge 32 percent of podiatric medical claims, 21 percent of dermatological claims and 25 percent of surgical claims. Blue Cross informs doctors that their practice style varies from that of their peers. Using that information, the physicians can adjust their performance accordingly. They are not, however, micro-managed.

"This is not a tool to threaten them and not pay them; it is a way to help them run their practice. We emphasize it that way," said Martin.

However, added Capor, "In the past, most of these doctors would've been scared to death to actually have to run a business, because there is a chance of failing. In medicine, you couldn't fail. Medical care is being moved into organizations, and being subjected to management for the first time."

Historically, management data has not been available to physicians. They viewed their practice one patient at a time. Moreover, doctors didn't know what their rate of service was, compared to one of their colleagues. One management tool that can be developed is at-risk capitation plans. In these plans, physicians' performance can be based on the severity of the illness of their patient. Financial incentives thus can be created for physicians — based on the savings they provide through their practice with each patient — rather than on their historic fee for service schedules.

"We're looking at what these physicians are producing: How much training, skill, time and stress do these procedures involve?" said Capor, who, earlier in his career served as chief of the medical staff of University of

Massachusetts Medical Center. "Let's begin to compensate them based on that, rather than what their historic charges have been." A group of chiropractors in Nebraska, hearing of some of the successes that Blue Cross and Blue Shield of Nebraska was having with information technology, recently approached the insurer, and asked how it could better manage its practice using the emerging methods.

#### Using newfound data

In addition to providing physician feedback, as in the case of the chiropractors, the technologies help create other information-based management tools.

One medical group reported to Codman Research Group that it noticed unusually high rates of emergency room admissions at one of its hospitals, after reviewing treatment patterns with the **software**. They found that the clinic that was supposed to serve the area only operated during bankers' hours. The residents of the blue-collar neighborhood were thus forced to go to the emergency room to receive even minor treatments. With the knowledge gained from the database, the medical group extended the hours of the clinic and saved operations expenses.

Moreover, medical **claims** fraud can also be discerned with this type of **software**. **Fraud** in this case would be when a **doctor** bills for a service never performed. Other false practices include billing for brand-name drugs when generic drugs were prescribed.

According to Kathleen Fyffe, director of payment systems at the Health Insurance Association of America, the tab for medical fraud can run to about 10 percent of the nation's \$1 trillion health-care bill. In 1989 alone, some 19,600 cases of medical claims fraud were reported in the U.S. Fyffe said information technology tools have the potential to aide immeasurably in the hunt for fraudulent billings. Much of that was in Medicare.

"Electronic environments can provide opportunities for us to improve our ability to detect health care fraud by virtue of generating more comprehensive and standardized data in which fraudulent billing patterns might be detected," said Fyffe.

Marcia Radosevich, CEO of Health Payment Review, developer of the **software** used to flag fraud, said expert systems had to be developed to service the needs of the insurance industry. "You can't have armies of physicians processing your claims for you," said Radosevich. "It wasn't until we figured out how to put physician knowledge into a rule-based, or an expert system, that we were able to deliver that sort of functionality."

#### **Software** developed with input from doctors

The **software** provided by vendors such as Codman and HPR is, in fact, developed in conjunction with scores of physicians, who serve as expert advisors to both companies. Their expertise of common billing practices is embedded into the **software**. "We're also developing two new products, and they're focused on bringing clinical knowledge to health-care services so that we can save costs and protect the quality of care," said Radosevich.

Generally, these products are licensed on a yearly basis, for fees ranging up to \$500,000. The cost depends on the size of the health plan. As niche players, the providers of this technology know that they have to offer products that can integrate with almost any **computer** system. HPR's products integrate with 15 platforms, from IBM AS400s to PCs, to HP 3000, DEC, and even UNIX-based **computers**, according to Radosevich. "One of our technological challenges was how to deliver this data so that we were not a customized program shop," she added. "We wanted to remain a **software** company, but one that is delivering into an industry that is widely divergent in the types of platforms it uses."

There are only a handful of information technology leaders, such as Codman and HPR, supplying this industry. And many information needs remain unmet. The 1,500 insurers in the U.S. use some 500 separate forms. About 4.6 billion claims were filed last year. Suppliers of electronic data interchange are becoming more active in the health-care market, though more than 95 percent of all medical forms are still created on paper.

"Assuming that EDI succeeds, there is still the issue of health-care documentation, especially source documents, and how that originating data is recorded and introduced on the information highway," said Dr. David Fox, president of Nestor Inc., Providence, R.I. "EDI will speed up, and lower the cost of data transmission and processing, but by itself it does not really address data integration."

Fox is touting intelligent character recognition, an advanced form of optical character recognition, as a product that



can help insurers receive 50 percent savings in data origination costs. Nestor continues to hold talks with health insurers around the country that are interested in this technology. Companies such as EDS are also interested in the market for the systems integration opportunities it provides, a spokesman said.

Thus far, more than 100 insurers, including Blue Cross and Blue Shield of Nebraska, have used some of the emerging information technology from HPR, Codman and others. Metropolitan Life, Tufts Affiliated Health Plan, and others that are moving toward the managed care mode of treatment have documented savings. "In the past, we were in the actuarial and claims business," said Martin, of Blue Cross and Blue Shield of Nebraska. "Now we're in the information business. Every insurer who plans to be in the managed care business had better invest in knowing their data. Without that data, you will never be able to reengineer the company."n \*\*\*\*

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